

# 4

## CHILDREN AND ADOLESCENTS AT RISK OF SUICIDE

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Suicide in children and adolescents is a major public health problem and accounts for at least 100,000 annual deaths in young people worldwide (World Health Organization, 2002). In the United States suicide accounts for more adolescent deaths than all natural causes combined, with approximately 4,000 young people ages 15 to 24 dying by suicide in 2002 (Kochanek, Murphy, Anderson, & Scott, 2004). The American Association of Suicidology (2003) estimated that in the United States a teenager kills him- or herself every 2 hours. Suicide ranks as the third leading cause of death in the United States among the 10- to 14-year-old and 15- to 19-year-old age groups, exceeded by only accidents and homicide (Anderson, 2002).

The Centers for Disease Control and Prevention's Youth Risk Behavior Survey found that of 1 million teenagers surveyed, nearly 20% seriously considered suicide in the past year, 15% made a specific plan to attempt suicide, and 9% reported an attempt; approximately 700,000 received medical attention for their attempt (Grunbaum et al., 2002). These results are consistent with those cited in other epidemiological studies in the United States (e.g., see Wichstrom, 2000).

Although suicide attempts are less common before adolescence, they increase significantly during adolescence, with a peak between ages 16 and 18 (Lewinsohn, Rohde, & Seeley, 1996). After age 18 the frequency of suicide attempts declines markedly, especially for young women (Kessler, Borges, & Walters, 1999; Lewinsohn, Rohde, Seeley, & Baldwin, 2001). As a result, the rate of suicide attempts across the life span is highest during adolescence, whereas the rate of completion is highest among persons older than age 65. For each youth suicide, there are approximately 100 to 200 youth suicide attempts (American Association of Suicidology, 2003). Researchers found that 31% to 50% of adolescents who attempt suicide reattempt suicide (Shaffer & Piacentini, 1994), with 27% of boys and 21% of girls reattempting within 3 months of the first attempt (Lewinsohn et al., 1996). Strikingly, 50% of adolescents who attempt suicide fail to receive any follow-up mental health treatment (Spirito, Brown, Overholser, & Fritz, 1989); of those who do receive treatment, up to 77% do not attend therapy appointments or fail to complete treatment (Trautman, Stewart, & Morishima, 1993). Suicidal behavior is the leading reason for admission to adolescent inpatient psychiatric units in the United States and abroad. With shorter lengths of stay mandated by managed care companies, psychiatric hospitals have become revolving doors for highly troubled youth. These data have major treatment implications, including the need for evidence-based treatments that effectively engage and retain high-risk suicidal youth in outpatient settings.

The evidence-based assessment and management of suicidality in children and adolescents is critical and complex for even the most seasoned clinician. In this chapter we offer a guide for working with this significantly at-risk population. First, we provide an overview of risk factors that inform the clinician's decision making between referring a patient for hospitalization versus continuing to treat the adolescent as an outpatient. Second, we offer strategies for evaluating suicide risk in children and adolescents. Third, we discuss managing this risk. The discussion of risk management includes a hypothetical case example to illustrate the key points.

Note that adolescent suicide attempts often have ambivalent—rather than certain—intention, further complicating their accurate assessment (King et al., 1995). Therefore, for our purposes we define a suicide attempt as self-injurious behavior with either ambivalent or certain intent to die.

## BIOPSYCHOSOCIAL RISK FACTORS

Suicidologists have worked vigorously to identify risk factors for suicidal behavior in youth. One of the greatest frustrations for clinicians, researchers, school personnel, family members, and friends is the inability to predict suicidal behavior among individual children and adolescents because it is a low base rate behavior (see chap. 3 for a discussion about suicide pre-

diction vs. suicide risk assessment). Research is limited by ethical problems, such as determining whether predictions are accurate. The best that can be done is to describe the characteristics of populations in which rates of suicide are higher than in the population as a whole. Thus, evidence-based assessment is helpful to evaluate risk factors commonly associated with suicide, rather than enabling one to say with conviction or certainty that an individual will commit suicide.

The research has clearly demonstrated the presence of certain distal (i.e., underlying vulnerabilities) and proximal (i.e., precipitating events) risk factors that when combined increase the probability of suicidal behavior. Suicide risk increases when these precipitating events occur in the context of the distal risk factors. Hence, Lewinsohn et al. (1996) hastened to point out that stressful life events should be considered red flags for clinicians. By the same token, experiencing one or more of these stressful life events by themselves need not alarm a clinician. Assessment of risk is complicated by the fact that some risk factors can be considered both distal and proximal. For example, social and environmental factors, such as family conflict and parental psychopathology, can function as proximal factors that cause or exacerbate existing mental disorders or psychological pain, which in turn increase the risk of suicide. Exhibit 4.1 lists the major distal and proximal risk factors that are highlighted.

## **Distal Risk Factors**

### *Prior Suicide Attempts*

It has become well established that a prior suicide attempt is one of the single most important predictors of completed suicide (Gould, Greenberg, Velting, & Shaffer, 2003), with a thirtyfold increased risk for boys and a threefold increased risk for girls (Shaffer et al., 1996). Numerous autopsy studies of adolescents who committed suicide have found high rates of previous suicide attempts, ranging between 10% and 44% (Marttunen, Aro, & Lönnqvist, 1992). Furthermore, in a study of adolescents who attempted suicide evaluated in an emergency department, researchers discovered 8.7% of the boys and 1.2% of the girls committed suicide within 5 years (Kotila, 1992).

### *Mental Disorders*

Clinical researchers agree that suicidal behaviors among adolescents are clearly associated with diagnosable mental disorders (e.g., see Kovacs, Goldston, & Gatsonis, 1993; Lewinsohn et al., 1996). Psychological autopsy studies have reported greater than 90% of adolescent suicide victims with a mental illness at the time of their death, although younger adolescent suicide victims tend to have lower rates of mental illness, averaging around 60% (e.g., see Beautrais, 2001; Brent, Baugher, Bridge, Chen, & Chiappetta,

# EXHIBIT 4.1 General Risk Factors for Adolescent Suicidal Behavior

Distal risk factors underlying vulnerabilities	Proximal risk factors precipitating events
Prior suicide attempts	Suicidal ideation
Mental disorders	Accessible means to suicide
Affective and anxiety disorders	Stressful adverse life events
Disruptive and antisocial disorders	Suicide in the social milieu
Alcohol and substance use disorders	Academic difficulties
Personality disorders	Childhood sexual and physical abuse
Comorbid disorders	Functional impairment from physical disease and injury
Demographic risk factors	
Gender	
Sexual orientation	
Ethnicity	
Socioeconomic status	
Family dysfunction and parental psychopathology	

*Note.* From *Dialectical behavior therapy with suicidal adolescents* (p. 12), by A. L. Miller, J. H. Rathus, and M. M. Linehan, 2007, New York: Guilford Press. Copyright 2007 by The Guilford Press. Reprinted with permission.

1999). Although a variety of mental disorders exist among adolescents who committed suicide, adolescents internationally are diagnosed with one of three classes of Axis I disorders: (a) affective and anxiety disorders, (b) disruptive and antisocial behavior disorders, or (c) alcohol and substance use disorders (e.g., see Fergusson & Lynskey, 1995; Gould et al., 2003).

*Affective and Anxiety Disorders.* Depressive disorders have been reported among adolescents who attempted suicide and those who committed suicide, ranging from 49% to 64% (Brent, Perper, et al., 1993; Shaffer et al., 1996), with rates highest among psychiatric inpatients (Spirito et al., 1989). Suicidal behaviors are common among adolescents with early-onset depressive disorders (Brent, Perper, et al., 1993). Kovacs et al. (1993) found a four- to fivefold increase in suicidal ideation and behavior among adolescents with affective disorders compared with adolescents with other mental disorders. These statistics are noteworthy because the risk of developing a depressive disorder increases as one gets older but rises dramatically between ages 9 and 19 (King, 1997). In addition, although bipolar disorder is less prevalent among adolescents, it has been considered a significant risk factor in many studies (e.g., see Brent et al., 1988; Geller et al., 2002).

Lewinsohn et al. (1996) identified anxiety disorders as a risk factor for suicidal behavior among adolescents. Goldston et al. (1999) reported trait anxiety to be predictive of posthospitalization suicide attempts, independent of mental disorder. In another study, investigators found that adolescents with a history of panic attacks were 3 times more likely to express suicidal ideation and 2 times more likely to report suicide attempts than those without a history (Pilowsky, Wu, & Anthony, 1999). Moreover, posttraumatic

stress disorder has also been associated with adolescent suicidal behavior (Giaconia et al., 1995; Mazza, 2000).

*Disruptive and Antisocial Disorders.* Several researchers have suggested that most completed suicides by adolescents are impulsive, with only about 25% providing evidence of planning (Hoberman & Garfinkel, 1988). Aggression with impulsivity has also been linked with suicidal behavior in children and adolescents (e.g., see Apter et al., 1995; Brent et al., 1994). A study of suicidal adults suggested that a personality style marked by pronounced impulsivity and aggression characterized individuals at risk of suicide attempts regardless of mental disorder (Mann, Waternaux, Haas, & Malone, 1999). It should not be a surprise that disruptive behavior disorders are a common diagnosis among suicidal adolescents (e.g., Kovacs et al., 1993), especially boys (Brent, Johnson, et al., 1993; Shaffer et al., 1996). Furthermore, Apter et al. (1995) suggested that aggression, a large component of conduct disorder, may be as important a risk factor as depression in some kinds of suicidal behavior.

*Alcohol and Substance Use Disorders.* Drug and alcohol use and abuse have been found with great frequency among those adolescents who attempted suicide and those who committed suicide and, consequently, are considered primary risk factors (e.g., see Shaffer et al., 1996). In a study of adolescent substance users, suicide attempts occurred at rates threefold those of nonsubstance using adolescents, with the wish to die increasing dramatically after the onset of substance use (Berman & Schwartz, 1990).

*Personality Disorders.* There is a reluctance to diagnose personality disorders in adolescents because of the commonly held belief that the adolescent personality is still evolving (Miller, Rathus, & Linehan, 2007). However, personality disorders and the tendency to engage in impulsive acts have become critical risk factors for completed suicide among adolescents (Brent et al., 1994). Completed suicide occurs in 8% to 10% of persons diagnosed with borderline personality disorder (BPD), and self-mutilative acts and suicidal threats and attempts are extremely common (American Psychiatric Association, 2000). Brent, Johnson, et al. (1993) compared inpatient adolescents who had attempted suicide with inpatient control participants who were never suicidal and found that suicidal clients were more likely than control participants to have personality disorders or features, particularly those of the borderline type. In addition, Velting, Rathus, and Miller (2000) found that adolescents who attempted suicide had higher levels of borderline behavioral criteria on the Millon Adolescent Clinical Inventory (Millon, Millon, & Davis, 1993).

*Comorbid Disorders.* Comorbidity of mental disorders is the rule rather than the exception among adolescents (Volkmar & Woolsten, 1997), and comorbid disorders are often present in adolescents who commit suicide (Miller et al., 2007). Depressed teenagers with comorbid alcohol and substance abuse, conduct problems, or BPD represent a particularly high-risk profile for suicidal behavior and completed suicide among teenagers (Kovacs

et al., 1993; Marttunen et al., 1995). Although most adolescents who make a suicide attempt have a diagnosable mental disorder, it is important to note that most adolescents with a mental disorder do not make a suicide attempt (Lewinsohn et al., 1996). Adolescents at highest risk for suicide tend to have high rates of comorbidity of both Axis I and Axis II disorders.

### *Demographic Risk Factors*

*Gender.* Although suicidal ideation and attempts are more common among females in the United States (Gould et al., 1998; Grunbaum et al., 2002), completed suicide is 5 times more common among 15- to 19-year-old males (Anderson, 2002). Studies have consistently found gender differences among adolescents who attempted suicide (Gould et al., 2003). Approximately 10% to 20% of girls versus 4% to 10% of boys report having made a suicide attempt during their lifetime. Hence, girls report attempting suicide 2 to 4 times as frequently as boys.

*Sexual Orientation.* Cross-sectional and longitudinal epidemiological studies found homosexual adolescents of both sexes to be 2 to 6 times more likely to attempt suicide than their heterosexual peers (Blake et al., 2001; Russell & Joyner, 2001). Garofalo, Wolf, Wissow, Woods, and Goodman (1999) found that self-identified gay, lesbian, and "not sure" youth were 3.41 times more likely to report a suicide attempt than their peers. In addition, they found sexual orientation to have an independent association with suicide attempts for male adolescents. For female adolescents, the association of sexual orientation with suicidality may be mediated by drug use and violence-victimization behaviors.

*Ethnicity.* In the United States, youth suicide is most common among Native Americans (Middlebrook, LeMaster, Beals, Novins, & Manson, 2001). Caucasian youth have higher rates than African American youth, with Asian/Pacific Islanders having the lowest rates. It is important to note that since the mid-1990s suicide rates have gradually declined among both Caucasian and African American male and female adolescents (Gould et al., 2003). Latinos have a relatively low suicide completion rate but are significantly more likely than either Caucasian or African American adolescents to report suicidal ideation and to have made a suicide attempt (Kann, Kinchen, Williams, & Ross, 2000; Tortolero & Roberts, 2001).

*Socioeconomic Status.* The data are mixed regarding the effect of socioeconomic status and suicide (Miller et al., 2007). Several studies have found that youth who have attempted suicide have higher rates of socioeconomic disadvantage than community control participants, even after controlling for other social and mental health risk factors (e.g., see Fergusson, Woodward, & Horwood, 2000). Other studies have found little effect of socioeconomic disadvantage on suicide victims generally after adjusting for family history of mental illness or suicide (Agerbo, Nordentoft, & Mortensen, 2002).

### *Family Dysfunction and Parental Psychopathology*

Various theories, coupled with research data, suggest that family functioning plays an important role in the etiology and maintenance of adolescent suicidal ideation and behavior (e.g., see Adams, Overholser, & Lehnert, 1994). A family history of suicidal behavior significantly increases the risk of completed suicide (Gould, Fisher, Parides, Flory, & Shaffer, 1996) and attempted suicide (Bridge, Brent, Johnson, & Connolly, 1997). Agerbo et al. (2002) found youth suicide to be nearly 5 times more likely in the offspring of mothers who have completed suicide and twice as common in the offspring of fathers, even after adjusting for parental mental disorder. Furthermore, parental depression and substance abuse have been associated with suicidal ideation, attempts, and completed suicide in adolescents (e.g., see Gould et al., 1996). Impaired parent-child communication and low levels of emotional support and expressiveness are also associated with adolescent suicidal behavior (e.g., see Wagner, 1997).

### **Proximal Risk Factors**

#### *Suicidal Ideation*

Suicidal ideation is a strong, if not one of the best, predictors of suicide attempts (Gould et al., 2003). Suicidal ideation generally requires that the adolescent has current thoughts of death, of killing himself, or of being killed. Some adolescents may present with passive suicidal ideation (e.g., "I wish I were dead") but report having no plan or intent to kill themselves. In contrast, some adolescents report active suicidal ideation that is more alarming (e.g., "I feel like killing myself"). When asked, these clients may report having a specific plan to kill themselves. A suicidal plan involves identifying a specific method and possibly a given time frame, in which an adolescent plans to kill him- or herself. After an adolescent reports having a plan the clinician must assess for suicidal intent, which characterizes the adolescent's level of commitment in carrying out the plan. Hence, adolescents may report having a specific plan but have no intent to die (e.g., "I thought about jumping, but I would never do it"). Others may describe their intent as ambivalent (e.g., "I think about taking an overdose, but I am not sure whether I can do it"), and still others may have full intent to kill themselves (e.g., "I intend to shoot myself this Sunday when my parents leave town"). Further complicating matters is the inconsistency across assessments in adolescents' reports of their own suicidal behavior (Velting, Rathus, & Asnis, 1998).

#### *Accessible Means of Suicide*

Accessibility to the means of suicide is a significant proximal risk factor. The most common method of suicide in the United States, regardless of age, race, or gender, is firearms (Minino, Arias, Kochanek, Murphy, & Smith,

2002). In 2001, firearms were used in 54% of completed youth suicides (Anderson & Smith, 2003). The probability of suicide increases 5 times when a firearm is kept in the home (Brent et al., 1991). Other common methods used by male adolescents for completed suicide in the United States include jumping, hanging, and carbon monoxide poisoning. For female adolescents, the next most frequent methods include overdosing on pills or ingesting solid and liquid poisons (Minino et al., 2002).

The overwhelming majority of adolescent suicide attempts in the United States and the United Kingdom involve intentional overdose (Berman, Jobes, & Silverman, 2006). Lewinsohn et al. (1996) found that ingestion and self-cutting accounted for 86% of the suicide attempts reported by girls and 45% of those reported by boys. In addition to ingestion (20%) and self-cutting (25%), they found that other common methods used by boys were gun use (15%), hanging (11%), and other (22%), which included activities such as shooting air into one's veins and running into traffic.

Medical lethality of method and suicide intent has been found to be highly correlated (e.g., see Robbins & Alessi, 1985), although certainly not synonymous. However, Harris and Myers (1997) found that adolescents who overdose without intent to die seriously underestimated the dangerousness of their actions. These data confirm that many teens have little understanding of the medical-biological consequences of their actions; some adolescents assume taking five extra strength Tylenol will kill them, whereas others believe that ingesting 100 of the same pills will merely help them sleep better.

### *Stressful Adverse Life Events*

Historically, interpersonal conflicts and separations are considered the most common precipitants to adolescent suicide (Miller & Glinski, 2000). Breakup of a romantic relationship, disciplinary or legal problems, and arguments are some of the stressful life events identified in attempted and completed suicide of youth worldwide, even after adjusting for family, personality factors, and psychopathology (e.g., see Beautrais, 2001). Specific stressors may vary depending on age. For example, romantic difficulties are common precipitants among older adolescents, and parent-child conflicts are common among younger adolescents (Miller & Glinski, 2000).

### *Suicide in the Social Milieu*

Exposure to the suicidal behavior of others, including through the media, can precipitate imitative suicidal behavior, at least in some individuals (Velting & Gould, 1997). Adolescents are highly susceptible to suggestion and imitative behavior, as these are primary modes of social learning and identity formation. Velting and Gould (1997) proposed that modeling cues through personal acquaintance, community exposures, and exposure to media coverage may all play a role in imitative suicidal behav-



ior. Numerous studies have found significantly more peers, friends or family members had attempted or completed suicide in the social networks or families of those who ideated about, attempted, and committed suicide than in control groups.

In addition to increased rates of suicidal behavior in the relatives and friends of suicide victims, suicidologists have examined cluster suicides. A suicide cluster may be defined as a group of suicide attempts that occur closer together in time and space than would normally be expected in a given community (Centers for Disease Control and Prevention, 1988). In a review of the suicide cluster literature, Velting and Gould (1997) argued that suicide contagion is a real effect, even though it appears to be a less potent risk factor than other psychiatric and psychosocial risk factors for suicide. In addition, adolescents are at highest risk for a cluster suicide.

### *Academic Difficulties*

School difficulties, not working or attending school, and dropping out of high school have been identified as risk factors for attempted and completed suicide in several countries, even after controlling for psychopathology and social risk factors (e.g., see Wunderlich, Bronish, & Wiichen, 1998).

### *Sexual and Physical Abuse*

Researchers have found that childhood sexual and physical abuse are also associated with suicidal behavior in adolescents, even after controlling for a variety of potentially confounding variables, including the adolescent's psychopathology, parental psychopathology, and demographics (Gould et al., 2003; Johnson et al., 2002).

### *Functional Impairment From Physical Disease and Injury*

Physical diseases and injury and related functional impairment have been found to increase the risk of future suicide attempts in adolescents (Lewinsohn et al., 1996). Nevertheless, certain diseases require more attention in this population. For example, a diagnosis of HIV/AIDS, although considered a more definitive risk factor among adults, has not received adequate empirical study among adolescents.

## EVALUATING RISK

To assess a new suicidal patient effectively, particularly in an outpatient setting, it is critically important to first conduct a thorough diagnostic evaluation, as certain mental disorders are clear risk factors for adolescent suicidal behavior. One of the most commonly used semistructured diagnostic interviews to assess Axis I disorders in children and adolescents is the Schedule for Affective Disorders and Schizophrenia for School-Age Chil-

dren, Present and Lifetime Version (Kaufman, Birmaher, Brent, Rao, & Ryan, 1997). Both the adolescent and the parent or guardian are interviewed separately to obtain diagnostic information. It must be noted that in certain settings, such as a hospital emergency department, acute care facility, or urgent care outpatient appointment, it may not be feasible to conduct a thorough evaluation because of the time required. In these cases, one must rely on diagnoses obtained from a standard clinical interview. Regardless, one needs to obtain specific information about the adolescent's suicidal ideation, plan, and intent. Sometimes an adolescent directly informs the therapist that he or she is feeling suicidal. The patient may be thinking or even planning a suicide attempt without directly informing the therapist. Should a therapist raise the question if the patient has not directly brought it up? The answer is a definitive yes. Ask questions about ideation, plan, and intent directly. The following are several occasions that may prompt a therapist to ask whether the adolescent is having thoughts about suicide: (a) the occurrence of an event that was a precipitant to a prior suicide attempt or serious suicidal ideation; (b) worsening of psychiatric symptomatology, especially depressive symptoms, panic attacks, or psychotic symptoms; (c) increasing amounts of alcohol or drug use; and (d) statements made by the adolescent, such as she wishes she were dead or she believes her family would be better off without her. Key questions about suicidal behavior include the following:

1. Given what you are saying about your current life circumstances, are you feeling hopeless or discouraged right now?
2. Have you been feeling so unhappy lately that you are having thoughts about death or of killing yourself? If yes,
3. Do you have a plan for how you would do this? What is it and do you have the means to carry this out (i.e., accessibility of instrument)? If yes to plan,
4. How intent are you on carrying out this plan? What is the likelihood of your actually doing it?
5. What reasons do you have to live right now (i.e., assessing for intent and protective factors)?
6. Have you ever attempted suicide before?
7. Have you ever injured yourself without intent to die? What about now (i.e., assessing nonsuicidal self-injurious behavior, which is an important risk factor for suicide)?

Research suggests that suicidal clients are more likely to disclose current suicidal ideation on a self-report measure than in a clinical interview (Kaplan et al., 1994; Velting et al., 1998). Nevertheless, it is equally important not to rely exclusively on self-report measures. A clinical interview yields important information that cannot be obtained through questionnaires, such as the adolescent's quality of affect and compliance with the interviewer (Velting et al., 1998). Some adolescents are reluctant to actively engage in

the evaluation process. At times, it is critical to check in with them, potentially validate their feelings that this is a difficult process, and then either take a break or establish a commitment that they will work with you to complete the evaluation.

When possible, a comprehensive assessment battery that includes semistructured diagnostic interviews in addition to parent, teacher, and adolescent self-reports is recommended. Examples of commonly used self-report inventories of suicidal ideation and behavior include the Suicidal Ideation Questionnaire (W. M. Reynolds, 1987), the Scale for Suicide Ideation (Beck, Steer, & Ranieri, 1988), and the Harkavy-Asnis Suicide Survey (Harkavy-Friedman & Asnis, 1989). Nock, Holmberg, Photos, and Michel, (2007) developed a new instrument called the Self-Injurious Thoughts and Behaviors Interview, which has strong psychometric properties to assess suicidal ideation and behavior as well as nonsuicidal self-injurious urges and behaviors among an adolescent population. One may also consider administering another self-report measure that approaches suicide from a different vantage point. The Reasons for Living Inventory for Adolescents (Osman et al., 1998), is a modified version of the adult questionnaire of the same name that taps expectancies about the consequences of living versus killing oneself and assesses the importance of reasons for living. This instrument functions to identify protective factors against suicide. Several additional self-report measures may be useful to use when working with this population, including the Beck Depression Inventory—II (Beck, Steer, Ball, & Ranieri, 1996), Symptom Checklist-90—Revised (Derogatis, 1975), and the Behavioral Assessment Scales for Children (C. R. Reynolds & Kamphaus, 2004).

## MANAGING RISK

In real-life clinical practice, it is rare to completely separate assessment from treatment when engaging in ongoing work with a suicidal adolescent. It feels necessary when writing about these issues to describe them in a more linear fashion. However, when evaluating an adolescent for the first time, it is usually best to first conduct a diagnostic evaluation and suicide risk assessment (through clinical interview and self-report measures) and then implement interventions that are known to effectively manage suicidal behaviors in youth. In this section we discuss the clinical management of suicidal behavior through the use of a youth suicide emergency protocol. Many of these principles derive from Linehan's (1993) work with suicidal adults and are equally applicable to teens.

To help clarify the protocol, we start by briefly describing an adolescent client referred for therapy to our outpatient adolescent depression and suicide program. Donna is a fictionalized 15-year-old African American girl who was referred by the psychiatric emergency department after expressing

suicidal ideation to her guidance counselor at school. At the time of the intake evaluation, Donna reported that she had been experiencing suicidal thoughts, sad mood, decreased appetite, anhedonia, and irritability for the past year. She stated that she had thoughts of killing herself by ingesting a large quantity of her mother's antidepressant medication and sleeping pills; however, she had not experienced any thoughts during the past week and a half, which she attributes to recently beginning a relationship with a boy in her school. Upon returning for the follow-up appointment, Donna tearfully reported to the intake therapist that her boyfriend broke up with her that morning and that she had gotten into a physical altercation with a girl at school the day before. She stated that she did not want to attend the appointment because "it won't help."

In Donna's case, the therapist was aware of her history of significant suicidal thoughts and depressive symptoms. Although Donna did not offer the information, the therapist directly asked about Donna's current level of suicidal ideation, plan, and intent. After the therapist's inquiry, Donna did indicate that she had been thinking about killing herself by overdosing on pills but was uncertain if she could carry out the act.

### **Delay Impulses and Restore Hope**

One of the greatest problems for suicidal youth is that they cannot see a way out of the pain they are experiencing. In these circumstances, therapists need to simultaneously use assessment and intervention strategies. Many suicidal patients describe their current experience as though there is a mountain of accumulated problems in front of them that appears insurmountable. Thus, the challenge for the therapist is to model how to break down this mountain into manageable problems that can be solved in the present. A protective factor for suicide is when the patient can identify reasons for living. The therapist can ask the suicidal patient, "What reasons do you have for living right now?" The therapist hopes that the patient does not require significant prompting. However, because suicidal patients are often in acute emotional distress, the therapist might prompt with statements such as, "What about your family and friends?"; "How would they feel if you killed yourself?"; "What about your future?"; "What do you want to be when you grow up?"; and "What about your religion?" If these reasons for living are significant, they can serve as a protective factor against imminent suicidal behavior.

With minor prompting, Donna was able to acknowledge the painful feelings she had when she considered how hurt her mother and family would be if she killed herself. The therapist was able to provide validation for the anguish Donna was feeling and help her recognize that she now had another advocate to help her to decrease her pain. In addition, the therapist told Donna that despite feelings to the contrary, she could make it through this difficult period if she gave the therapist a chance to help. The therapist re-

minded her of prior occasions that Donna had *stuck it out* and came out on the other side feeling better. If recalling past coping successes is ineffective, the therapist can use irreverent statements such as, “How do you know you will feel less upset after you kill yourself?”; “Why don’t you give us a chance to work on solving your problems and lessen your pain?”; and “What do you have to lose?”

If the patient cannot identify any reasons for living and is unable to demonstrate any future perspective in terms of goals, the therapist must recognize this as an absence of protective factors that needs to be factored into the decision about psychiatric hospitalization.

### **Problem-Solve the Current Problem**

Frequently, the adolescent’s assumptions about the outcomes of his or her behavioral choices are unrealistic and need to be gently but directly confronted. Ideally, therapists help patients generate their own solutions to their problems. However, in an emergency there are times when the patient does not know what to do. In these circumstances it is advisable for the therapist to give direct, concrete suggestions about how to manage specific situations (Miller, Nathan, & Wagner, in press). Therapists should be careful not to assume that a patient who generates a solution also knows exactly how to carry it out. Thus, therapists should pay attention to these details and generate solutions for the patient to try.

The therapist was able to recognize that Donna was overwhelmed by her emotions and suicidal thoughts. The therapist helped Donna identify that she had survived these thoughts and feelings before by using specific strategies, including talking with her mother, listening to music, and writing poetry. For Donna, the long-term goal of therapy was to learn to affiliate with people, particularly boyfriends, who would treat her respectfully. The therapist, however, helped Donna focus on the short-term goal, which was to get through this suicidal emergency situation. As a result, in addition to helping Donna identify strategies for managing her emotions, the therapist also made herself available by pager 24 hours a day and added an additional session later in the week to increase social support.

### **Reduce High Risk Behavioral Factors**

Regardless of whether the lethal means is a gun, liquid poison, or pills of some sort, it is imperative that the therapist spend a portion of the emergency session ensuring that the removal of lethal means has occurred or will occur. Depending on the acute nature of the emergency, the therapist may instruct the patient to bring the lethal items to the next session or insist that the patient go home and bring in the items immediately. In other cases, when the patient calls the therapist in a suicidal emergency, the therapist

may instruct the patient to flush the pills down the toilet and should wait on the phone while the patient complies. In other cases, family members, significant others, or roommates may be enlisted to facilitate the removal of lethal means from the patient's home. Locking up a firearm in the home or separating the ammunition from the gun is not sufficient. The weapon needs to be secured outside of the home.

Because Donna is a minor, the therapist brought Donna's mother into the session to inform her of Donna's suicidal thoughts, plan, and possible intent. The therapist specifically asked Donna's mother whether all the medications in the house were locked away and told her that if they were not, she should insure they were as soon as they returned home. Donna agreed to this plan, stating that she did not trust herself with access to the pills.

If the adolescent refuses to consent and is noncompliant with the therapist's recommendations to remove lethal items herself, it is typically a bad prognosis regarding the adolescent's willingness and capacity to maintain safety and thus may require an inpatient admission. Either way, because suicidal behavior is at issue, the therapist is justified in breaking confidentiality by contacting a family member to remove the lethal means. In addition, some patients self-medicate with drugs or alcohol. During a suicidal emergency, the patient needs to be instructed to discontinue any alcohol or drug use because of their disinhibiting properties. If the adolescent is unwilling to discontinue drug or alcohol use, the therapist must factor this high-risk behavior into the decision about psychiatric hospitalization.

### **Commit to a Plan of Action**

After a sufficient number of solutions are generated, the therapist asks the patient to commit to a plan of action. Considerable evidence suggests that the commitment to behave in a particular way, especially when the commitment is made publicly instead of privately, is strongly related to future performance (Linehan, 1999). First and foremost is obtaining the patient's commitment to not engage in any suicidal or self-harm behaviors until the next session.

Donna, with the therapist's assistance, identified the specific strategies she would use to survive this emergency situation. She committed to staying alive until the next scheduled session and agreed to tell her mother if her suicidal thoughts became unbearable. She also agreed to tolerate distress by listening to music, writing poetry, and calling her friends on the phone. Donna informed her mother about the plan.

### **Troubleshoot the Plan—Tolerate Distress**

Therapists working with suicidal patients need to suggest that one additional solution to their problems is to simply tolerate the painful conse-

quences, including the negative affect, that the situation has generated. At first blush, many suicidal patients have trouble grasping the value and function of this solution. However, with practice, patients begin to recognize and appreciate the idea of tolerance as a solution.

In Donna's case, the therapist validated her pain and normalized that anyone would feel this way after an abrupt breakup of a romantic relationship. The therapist noted that although it sounded strange, "Learning how to tolerate pain and disappointment is a difficult and important life lesson. I don't wish pain and disappointment on anyone, especially you, Donna, but I actually think this is an opportunity for me to help you learn how to soothe yourself during difficult times in your life."

## TROUBLESHOOTING AND RELAPSE PREVENTION

Despite the therapist's best efforts to effectively deliver interventions and the patient's apparent commitment to follow through, it is inevitable that obstacles will arise. Troubleshooting refers to anticipating obstacles before they occur and proposing solutions for managing them. When working with suicidal patients, it is even more imperative to troubleshoot the solutions, as it can be a matter of life and death.

The therapist asked Donna, "So what might interfere in your ability to write poetry, listen to music, or reach out to me or your mother if and when you feel suicidal later tonight or tomorrow? Might you be afraid to 'bother me' or not be in the mood to write? What then?" The therapist and Donna problem-solved how to manage these potential obstacles.

### **Anticipate Recurrence of Emergency Response**

The therapist anticipated that, for Donna, thinking of the boyfriend or focusing on her feelings of rejection might exacerbate her suicidal response. Although this is predictable, the therapist wanted to review with Donna how she will manage the situation (see previous troubleshooting discussion).

### **Reassess Suicide Potential**

Although the protocol for handling suicidal emergencies is basically the same regardless of whether they occur at the beginning or during the course of treatment, there are important differences: At the initial evaluation, there is not yet a therapeutic alliance to use in handling the situation, and the therapist does not know the patient or his or her biggest vulnerability factors or strengths. Although these differences may seem to suggest higher risk and a necessarily poorer outcome, the converse may actually be true:

Evidence indicates that youth and their parents may be more likely to follow through with treatment when presenting in a more acute state of distress (e.g., see Kendall & Sugarman, 1997).

### **Intersession Contact**

Interpersonal supports are a protective factor for the suicidal patient. Thus, in addition to coaching the patient on enlisting her family members and friends for support whenever possible, therapists must also make themselves available during these potential emergencies. The general rule is to stay in contact with the patient, either in person or by phone, until the therapist is convinced that the patient will be safe after the contact is broken off (Linehan, 1999). At these times, therapy sessions or phone calls may need to be extended until a safety plan is established and the patient is committed to comply. We suggest that therapists who carry pagers encourage their patients to make use of this method of contact. All therapists who work with suicidal patients should keep the names, phone numbers, and addresses of their clients handy in case of an emergency in which they may need to send an ambulance to their home.

Depending on the imminent nature of the emergency, the therapist may contact the parents or guardians and other treatment providers. The therapist should attempt to select the least intrusive intervention necessary (i.e., notify the fewest number of additional parties) to ensure the patient's safety. That is often a challenging judgment call to make when the issue of suicidality arises. Naturally, contacting an adolescent's parent or parents is a necessity when an acute suicidal emergency occurs or when an adolescent's low-level chronic suicidality worsens. Moreover, a nonmedical therapist should always notify the adolescent's prescribing doctor (if there is one) regarding the patient's increased risk of overdose. In addition, suicidal adolescents and their significant others (if appropriate) are always referred to their local psychiatric emergency department or told to call 911 if the suicidal impulses escalate and they are unable or unwilling to contact their therapist. In Donna's case, the therapist offered Donna an additional session later that week and reviewed the fact that Donna could page the therapist any time, day or night, for skills coaching to manage suicidal impulses.

### **Give Emergency Card**

All suicidal patients should receive an emergency card by the time they leave the session. At a minimum, the emergency card contains important telephone and pager numbers for all designated people. Additionally, some emergency cards contain a list of personalized coping skills.



## WHEN SHOULD INPATIENT PSYCHIATRIC HOSPITALIZATION BE RECOMMENDED OR CONSIDERED?

Although more suicides occur in the community than in hospitals, there are no empirical data to date that support the notion that acute, inpatient hospitalization is effective at preventing suicide. Moreover, no studies have found inpatient hospitalization to be the treatment of choice for the chronically suicidal patient (Linehan, 1999). However, on the basis of clinical experience, there are situations in which the therapist should consider recommending brief, inpatient hospitalizations. The following is a list of potential circumstances that may warrant this type of recommendation; the first five are adapted from Linehan (1993):

1. The patient is psychotic and is threatening suicide or having command auditory hallucinations to kill himself or someone else.
2. The patient is on psychotropic medications, has a history of overdose on these medications, and is having problems that require close monitoring of medication or dose.
3. The relationship between therapist and patient is severely strained, which is contributing to the suicidal emergency. The inpatient staff might be helpful in repairing the relationship by facilitating a meeting with both parties.
4. The patient is not responding to outpatient therapy and there is severe depression or debilitating anxiety.
5. Operant suicide threats are escalating and hospitalization is considered aversive by the patient.
6. The patient is actively abusing alcohol or drugs and is refusing to reduce usage during the emergency.
7. The patient refuses to remove lethal items from the home or refuses to use an emergency card to call the therapist or others if suicidal ideation returns.
8. The patient is profoundly hopeless and unable to identify any reasons for living, even with prompting.
9. The patient cannot identify any social supports that she is willing to use for help during the emergency period.

This list is not meant to be exhaustive but merely represents several common situations that may, individually or in combination, warrant inpatient admission for the suicidal patient. Of course, each of these situations needs to be considered in a fuller clinical context. The therapist must always take into account the patient's prior history of suicidal behavior, current suicidal ideation, plan, and intent, as well as the myriad of environmental and behavioral high-risk factors.

## CONCLUSION

The field of adolescent suicidology is advancing. In this chapter we highlighted the expanding list of evidence-based suicide risk and protective factors useful for evaluating the at-risk youth as well as managing suicidal crises. Although we did not focus on the ongoing treatment of suicidal youth, we presented a crisis protocol to be used during an acute 1- or 2-day suicidal crisis period with a clinical vignette to illustrate the principles. In addition, we offered recommendations about when to hospitalize a suicidal teen. Although the evaluation and management of suicidal children and adolescents can be stressful and overwhelming to even the most seasoned therapists, knowledge about and practice with a protocol focused on decreasing suicidal behaviors and increasing effective coping strategies can provide significant short- and long-term benefits for these youth and their families.

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